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Case Report

Applying a Multicomponent Framework to Manage School Refusal: A Case Report

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Abstract

Introduction: This paper presents the rationale of applying a combined cognitive behavioral and dialectical approach with parent management strategies to a case of anxiety-based school refusal. School refusal is a serious concern that causes much subjective distress to the child, placing his/her parents under tremendous stress. It negatively impacts the child's self-worth and psychological well-being, and also interferes with social and educational development. The condition is frequently co-morbid with emotional difficulties including depression and anxiety in children and adolescents.
Method: The client in this study is a 17-year-old boy with an above average intelligence level presented with school refusal, along with symptoms of anxiety, obsessive worry and excessive reassurance seeking behaviors. Initial assessments using the Children's Global Assessment Scale (CGAS) revealed moderate impairment in the social area and severe impairment in the academic area. The client showed clear difficulties in emotion regulation, in terms of a higher use of expressive suppression and lesser use of cognitive reappraisal, which were identified on the Emotion Regulation Questionnaire (ERQ). Psychotherapy involved weekly sessions of Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT) techniques including facilitating exposure, cognitive restructuring, distress tolerance, effective goal setting, and interpersonal effectiveness skills in the family context. Changes were assessed at 6 months, 12 months and 18 months follow-up.
Results: Results showed reductions in subjective anxiety and reassurance seeking behaviors, and an increase in distress tolerance, with a higher use of cognitive reappraisal. Improvements in interpersonal effectiveness in the family context were noted. The CGAS and ERQ ratings at 6 months, 12 months and 18 months follow-up showed steady improvement, with the client resuming regular schooling.
Conclusion: A combined cognitive behavioral and dialectical behavioral approach can be useful in managing school refusal. This case report emphasizes the need for further research to understand the effectiveness of multicomponent approaches to school refusal.

Keywords: School Refusal, Emotion Regulation, Cognitive Behavior Therapy, Dialectical Behavior Therapy

Introduction

School refusal is a term that describes motivated refusal to attend school, or difficulty remaining in school throughout the day [1]. The behavior persists despite efforts to reinforce school attendance, and remains a huge source of stress for the child and his/ her parents. School refusal could stem from (a) avoidance of school-related objects or situations that cause distress or negative affect, (b) wanting to escape aversive social and/or evaluative situations, (c) receiving attention from others outside of school, or (d) wanting to pursue reinforcement outside school [2].

School refusal commonly has emotional manifestations, and is frequently co-morbid with clinical depression and anxiety in children and adolescents. Results from an Indian research study showed that 87.9% subjects presenting with school refusal to a psychiatric service in

South India had a psychiatric diagnosis at baseline. Depressive disorder (63.6%) was the most common diagnosis followed by specific phobias (30.3%). Psycho-social factors played a role in a majority of the subjects (87.9%) [3]. More recently, it was found that 77.8% of children with school refusal who were treated at a child guidance clinic in Mumbai, India had a psychiatric diagnosis, the most common being depression (26.7%), followed by anxiety (17.7%). School refusal was predicted by four factors, namely academic problems, difficulties adjusting at school, behavioral problems, and parental conflicts [4].

Cognitive Behavior Therapy (CBT) appears to be one of the most useful treatments for school refusal. However, the efficacy of CBT has been regarded as moderate, as per a review of psychosocial treatments for school refusers [5]. While younger children show an encouraging response to contingency management and exposure-based interventions, older children are known to respond much better to cognitive-behavioral therapy. However, clinical conditions such as depression may make the child less amenable to these interventions, owing to heightened distress levels in the child as well as his or her parents [6]. It has long been established that emotion dysregulation underlies various manifestations of psychopathology. In particular, avoidance, rumination and suppression of emotions have been positively associated with anxiety and depression, while cognitive reappraisal seems to have a marginal negative relationship with anxiety [7]. There is evidence to suggest that emotion regulation based therapeutic approaches (ERT) with adolescents are effective in the context of major depression, generalized anxiety and social anxiety [8, 9]. An ERT based approach for social anxiety comorbid with clinical depression was found to have favorable outcomes in terms of reduced symptomatology, healthier emotion regulation, and greater well-being [8]. Similar results were found when ERT was applied to a case with generalized anxiety disorder [9]. Since school refusal is closely tied to anxiety and depression, it is possible that emotion dysregulation plays a significant role not just in maintaining school refusal behaviours, but also in one's response to treatment. On one hand, the child may be unable to manage his distress levels, and underestimate his ability to cope with anxiety-provoking situations at school, or with social and academic pressures; while on the other hand, parents who are unable to manage their own emotions may provide a dysfunctional coping model for the child. It is said that CBT may not address directly (or sufficiently) these issues with emotion dysregulation that may play a perpetuating role in dysfunctional cognitions. Research comparing clinical and non-clinical samples of children demonstrates that children with school refusal have clear emotion regulation difficulties, in that they report a higher use of expressive suppression and a lesser use of cognitive reappraisal [10]. In an attempt to address these issues, a recently developed unique approach based on the Dialetical Behavior Therapy (DBT) framework to target school refusal demonstrated that there was an incremental benefit to both parents as well as children [11].

It has become apparent that solely applying a cognitive behavioural perspective to manage anxiety-based school refusal may have its limitations, and therefore a more comprehensive approach is called for, to address underlying emotion regulation issues. The current paper outlines the application of CBT and an emotion regulation framework using elements from DBT, in a case with anxiety presenting with obsessive compulsive symptoms and school refusal. Combined interventions grounded in CBT and DBT principles have been utilized in the past with suicidal behaviour [12], generalized anxiety [13, 9], and post-traumatic stress disorder [14], however, this combined approach is yet to be rigorously examined in the context of school refusal.

Case History

MD is a 17-year-old boy from a South Indian city who resides in a joint family set-up with his parents and paternal uncle's family. He was apparently functioning well until two and a half years ago, when he started showing a slight academic decline, along with symptoms of anxiety.

MD reported that his transition from the 8th to the 9th standard was stressful, as his homework assignments and general course work had increased. The primary reasons for his anxiety involved not being able to complete homework on time and failing his exams. His anxiety was more focused on future hypothetical events, about which he would constantly worry. For instance, he worried about whether he would pass his 10th grade, and subsequent to that, whether he would pass his 11th and 12th grade. He also worried that he will be unable to understand what was being taught in class, and imagined scenarios where the teacher would beat him if he tried to clarify his questions. None of these incidents had actually occurred, and yet they continued to be a source of great anxiety for MD. His parents would respond to his doubts in a positive and reassuring way. However, he was not satisfied with their responses and would continue to ask the same questions repeatedly. This reassurance seeking increased in the mornings before going to school, and he would refuse to go to school until his parents reassured him repeatedly. He subsequently stopped going to school altogether and stayed at home for a year. He spent all his time watching television and playing games on his play station, which his parents did not feel the need to check. While at home, his anxiety levels continued to be high, as he worried about the consequences of not going to school. His teachers were quite bewildered by his absence, as they considered him a quiet, hard-working student with good grades.

MD is an only child. His father holds a clerical job in a private organization, while his mother is a housewife. They had initially been quite tolerant of MD's school refusal, but began to feel frustrated as his absences became longer. MD's father occasionally tried setting limits, but was resented for making comparisons between MD and his cousins who were doing well in school. Enmeshment in the mother-child relationship was observed. His mother believed that providing constant reassurance and support

would help him, and refrained from exerting any form of authority or discipline. She would give in to MD's unreasonable demands such as doing his homework assignments and making excuses to his teachers regarding his absences from school. Both parents also positively reinforced his absences by allowing him the free use of the television and play station.

MD sought treatment and was admitted to a Child and Adolescent Mental Health Center, where he was initiated on medication for his anxiety. His intelligence was assessed, and was found to be above average. MD was discharged shortly, and was referred for further assessment and long-term psychotherapy.

Method

Significant findings on the Mental Status Examination revealed obsessive worry about future events related to school (for instance – "what if the teacher beats me if I ask a question in class?" or "what if I have difficulty grasping what is being taught?").

Further assessments with the client included the Children's Global Assessment Scale (CGAS) [15], the School Refusal Assessment Scale (SRAS – Revised) [16], and the Emotion Regulation Questionnaire (ERQ) [17]. All three scales displayed robust psychometric properties.

The Children's Global Assessment Scale (CGAS) [15] was developed to provide an overall measure of level of functioning in children and adolescents. The scale provides a single global rating ranging from of 0 to100, higher scores signifying better overall functioning. The measure was found to have excellent inter-rater reliability and a test-retest reliability of 0.85. It was also found to be sensitive to varying levels of impairment, in that it was capable of significantly differentiating between children who were being treated as inpatients and outpatients at a New York clinic [15]. MD obtained a global score of 43, signifying obvious problems with moderate impairment in social functioning and severe impairment in personal functioning in terms of school refusal manifested with severe anxiety symptoms.

The School Refusal Assessment Scale (SRAS – Revised) [16] is a 24-item scale designed to assess four conditions maintaining school refusal, namely negative affectivity, negative reinforcement, attention seeking and tangible reinforcement. Concurrent validity using diagnostic information revealed that internalizing problems were more common amongst adolescents refusing school for negative reinforcement. Further, separation anxiety disorder was more common amongst adolescents refusing school for attention. Finally, externalizing problems such as conduct disorder were more common amongst adolescents refusing school for tangible reinforcement. The scale shows good internal consistency, adequate stability over time, and between parent raters [16]. MD's scores revealed that the primary reason for refusing school was to avoid objects or situations that provoke general distress/negative affectivity. The results also showed elevated scores on the functions of refusing school for attention and refusing school to pursue tangible reinforcement outside school.

The Emotion Regulation Questionnaire (ERQ) [17] is a 10-item scale assessing strategies of cognitive reappraisal and expressive suppression. Higher scores reflect a greater use of the respective emotion regulation strategy. The scale displays good internal consistency scores (0.79 for cognitive reappraisal and 0.73 for expressive suppression), test-retest reliability of 0.69, and adequate convergent and discriminant validity with younger and older adult samples [17, 18]. MD's scores suggested a poor use of cognitive reappraisal (score = 31), and a higher use of expressive suppression (score = 25). An item analysis revealed tendencies to control his emotions without expressing them (indicating expressive suppression) and difficulties in changing the way he thinks about a situation that might help him stay calm (indicating a lack of cognitive reappraisal).

MD may have had a predisposition to anxiety, as his premorbid personality indicates that he had a tendency to be apprehensive in new situations, tending to avoid rather than to approach them. Early cognitive schemas related to apprehension and avoidance may have been activated during his transition from the 8th to the 9th standard, which he describes as very stressful.

One of the key maintaining variables for MD's school refusal (as seen on the SRAS – R) was his avoidance of situations that provoke general distress/negative affectivity, coupled with evidence from the ERQ that he was poorly equipped to manage this negative affect, resulting in attempts to suppress these unpleasant feelings. This caused additional distress and occasionally caused him to break out in bouts of temper towards his parents. Furthermore, his high levels of anxiety and lack of awareness of how to manage it led to school avoidance, bargaining with his parents on going to school, as well as repeated reassurance seeking behaviors. MD's strengths however, included a realization that he needed to go back to school, and acceptance of treatment.

Parental role in maintaining the problem involved giving in to reassurance-seeking behaviors. MD would experience overwhelming anxiety especially in the mornings when he was expected to go to school. This resulted in repeatedly asking his mother for reassurance. His questions revolved around whether school was really necessary, whether he was capable of doing well in his studies, and whether his principal or teachers would punish him for his absence. His mother always patiently answered these questions in the most reassuring manner hoping it would convince him to go to school, however, to no avail. This became a regular pattern which offered no productive solution for the client or his mother. In fact, her responses reinforced further reassurance seeking. MD's mother also negatively reinforced MD's avoidance behaviors by finishing his home-work assignments for him and allowing long absences. Both parents also positively reinforced his absences by allowing him the free use of the television and the play station. Early on, MD's parents hesitated to set clear limits on unacceptable behaviors and this had set the trend of the dynamics between them. However, the parents' strengths were their

concern and determination for MD to get better, which showed in their commitment to therapy.

A combination of a CBT and DBT based therapeutic approach was used owing to (a) the irrational beliefs and dysfunctional reinforcement patterns that maintained school refusal, and (b) the significant levels of distress, negative affectivity, and poor self-regulation. The client was observed over a follow-up period of 6 months, 12 months and 18 months.

Results

Psychological intervention involved weekly sessions consisting of a variety of cognitive behavioral techniques and strategies to improve emotion regulation. The initial focus of therapy was to help MD deal effectively with his anxiety at a physiological level. Deep breathing exercises were practiced during sessions, and MD was gradually able to use them whenever his anxiety levels increased. Guided imagery was used not just as a relaxation strategy, but aimed to actively minimize MD's engagement in his obsessive thoughts. MD's daily routine was structured to incorporate more outdoor activities. MD agreed to collaborate, on the condition that he engaged only in non-academic activities. He joined evening tennis and morning yoga classes of his own interest and was able to follow it up over the next few months. This not only exposed him to social situations with people his own age (in non-anxiety provoking situations), but also prepared him to wake up and leave home early.

Cognitive work with MD involved helping him become aware of thoughts which led to anxiety in him.MD believed that he was a failure as he had missed two whole years of school and was convinced he wouldn't be able to catch up with the rest of his classmates. He also believed that he was helpless to change the course of his future and that he had let his parents down. MD's negative assumptions were individually challenged in therapy, presenting realistic evidence that was contradictory to his beliefs (e.g. his past academic performance which was very good, his past experiences of resilience in difficult situations, the unconditional love and support of his parents). MD was encouraged to maintain a cognitive diary to record his thoughts and feelings in anxiety provoking situations, and was taught to challenge his own negative automatic thoughts.

Elements from a modified DBT approach with adolescents were integrated into the therapeutic process [19, 11]. Modified DBT with adolescents encourages family involvement in the therapeutic process, especially as the individual's emotion regulation problems are seen in the context of an invalidating environment. MD was encouraged to remain aware of his anxiety in the present moment without attempting to suppress his feelings. Since his poor distress tolerance was the primary reason for his repeated reassurance seeking behaviors and occasional anger outbursts with his parents, he was encouraged to identify self-soothing techniques. For instance, he found that listening to Indian classical music helped calm him when he was anxious, especially because it reminded him of his grandparents with whom he had a loving relationship. He sometimes reported that his anxiety was so overwhelming that listening to music didn't help. At such times, he was encouraged to use active distraction techniques to reduce the intensity of his emotions. This would then be followed by a reflective period of understanding triggers (which were mostly cognitive) and challenging his irrational assumptions in the situational context.

Parent-based strategies involved establishing a regular morning, daytime and evening routine for MD. In addition, contingency management procedures to manage school attendance were introduced. For instance, MD was only allowed to watch television or use his play station on the days when he attended school. Parents were urged to discourage reassurance seeking behaviors by cutting down on their responses to his repeated questions. Training them on practical techniques to deal with school-refusal in the morning – such as using clear, firm statements and modeling confidence – proved very useful. Both MD and his parents reported that they benefitted from Relationship Effectiveness Skills based on the DBT exercise of D.E.A.R.M.A.N. (Describe, Express, Assert, Reinforce, Mindful, Appear Confident, Negotiate), as it helped them to have more positive interactions with each other, without letting the situation become emotionally explosive. MD's parents learned to display confidence in their interactions with him. Also, MD reported that this exercise helped him to see things from his parents' perspective and be open to negotiation especially with regard to television and use of the play station.

MD's CGAS rating after 6 months was 50, reflecting a slight improvement in obsessive thinking and worry. His scores on the ERQ showed improvement in terms of expressive suppression (score = 21), however, there was only a minor improvement in cognitive reappraisal (score = 29) indicating that his thought patterns still tended to be clouded by his emotions, and he needed continuing cognitive work. CGAS rating after 12 months showed improvement at 58, indicating a few noticeable problems with variable functioning. His ERQ scores also showed improvement (expressive suppression = 17 and cognitive reappraisal = 25). MD's CGAS rating at 18-month follow-up was 68, showing some difficulty in the personal area (with respect to his anxiety), but generally good functioning. There was a further drop in his ERQ scores (expressive suppression = 16; cognitive reappraisal = 23) indicating that he continued to challenge his irrational thoughts.

Discussion

There were a few process related issues in therapy with MD. Firstly, rapport building was a challenge as he began each session with trying to establish control over the proceedings and bargain on activities. However, on establishing limits and introducing differential reinforcement in the therapy process, MD was more amenable to therapy.

Secondly, MD's initial response to his parents refusing to give in to his reassurance seeking behaviors was to lash out in anger. This caused them to feel anxious and guilty about causing him discomfort. His mother was particularly

ambivalent about remaining firm as she was over-involved in MD's academics and seemed to foster his dependency. However, she realized that being able to tolerate her own unpleasant feelings in tough situations with MD, helped him ease into a consistent academic routine over the next few months.

the subsequent months following therapy, MD began to realize the importance of education. This resulted in a joint decision with his parents to attempt his 10th grade exams through an open university. MD willingly enrolled himself in coaching classes on weekday mornings. His initial attendance was smooth; however, his obsessive doubts kept resurfacing, resulting in further absences. MD was encouraged to carry out behavioral assignments such as going up to his teacher to ask a question, to test his assumption that the teacher would beat him. MD agreed that his assumptions were not based on reality, and continued to attend classes, though not regularly. MD began to prepare for his 10th grade exams and felt overwhelmed with the syllabus, which caused him further anxiety, however at this time he was able to manage his anxiety much better, using distress tolerance techniques. He brought his books into the therapy sessions, where he was encouraged to break down the syllabus into smaller units and chart out a study schedule for the next 4 months. He was also taught how to utilize study skills and exam strategies. Despite his ups and downs, MD appeared for his exams and passed his 10th grade with above average marks. This brought him a great sense of achievement and boosted his self-confidence.

Subsequently, MD decided to rejoin a mainstream school for his 11th standard. An attendance plan was developed along with his parents, who were able to take the school authorities into confidence to gain their support in MD's treatment. MD joined school but showed fluctuations in attendance possibly due to too many unrealistic expectations of himself at an early stage. However, he continued to progress, albeit slowly, by learning to challenge his irrational assumptions, and successfully manage his anxiety.

Conclusion

MD's medication for anxiety was subsequently tapered down by his psychiatrist. MD reported a decrease in subjective levels of anxiety and more positive affect. He is currently attending school and is making slow but sure progress. It is expected that with continued intervention, his currently stable condition will be maintained. What seemed to work well was the combination of cognitive behavioral and emotion regulation strategies, with parent management techniques. This case emphasizes the need to go beyond a pure cognitive-behavioral approach for school refusers. The paper also points to the need for further research to understand the effectiveness of multicomponent approaches to school refusal.

Conflict of interest

The author declares no conflict of interests.

Ethical Approval

Although the client was initially brought into therapy by his parents, it was his decision to actively participate in the therapeutic process during the ensuing sessions, as he believed that he needed professional intervention in order to resume school. Consent of the client and his parents was obtained for the case to be published, assuring them of anonymity with respect to their personal details.

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